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ABSTRACT

The role of therapeutic recreation in psychiatric settings is examined. The importance of establishing a positive communication pattern is emphasized. Elements of assessment in the therapeutic recreation setting are considered, including thought processes and verbal behavior, nonverbal behavior, and awareness of feelings. Treatment planning is viewed as a process, with goals required as part of the individualized treatment plan. Examples are cited of descriptive observation and charting. (CL)

PRACTICAL POINTERS

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THERAPEUTIC RECREATION SERVICE IN PSYCHIATRY: ELEMENTS OF COMMUNICATION AND ASSESSMENT

Michael E. Crawford

IN THIS ISSUE

Michael Crawford draws from his background and experience as a trained rehabilitation counselor and registered therapeutic recreation specialist to provide materials for this Practical Pointer. With expertise and finesse, the author shows ways in which therapeutic recreation specialists can contribute significantly to psychiatric rehabilitation and recuperation of patients with various emotional and psychological problems. Although approached in terms of the patient and clinical environments, these methods and techniques can be applied in other situations by persons in various leadership positions. Importance of interpersonal relationships between two people and necessity to be a good listener and accept the individual as a person of worth and dignity, regardless of present circumstances, comes through loud and clear. We are indebted to Michael Crawford, instructor of therapeutic recreation and perceptual-motor dysfunction and coordinator of the perceptual-motor clinic, University of Nebraska-Omaha, for his third outstanding contribution to the Practical Pointer series.

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Basis of therapeutic recreation is that recreation can be used as a planned and purposeful intervention to bring about desired changes in a client's behavior and promote his/her growth and development. Assessment and evaluation[1] are keys to understanding an individual's needs and unique characteristics and, thus, bases for developing individual recreation treatment plans. Through assessment, a therapeutic recreation professional and other professionals determine an individual's strengths and weaknesses regarding one's present levels of adaptive behavior. Evaluation is imperative to determine future direction in terms of objectives, activities, and leadership techniques. After initial assessment there should be continuous evaluation. Just as the therapeutic relationship continues to grow and change, so do program goals.

Development of Communication Skills

Understanding the importance of therapeutic communication and self-examination of verbal and nonverbal communication skills is one of the primary tasks of therapeutic recreation specialists in psychiatric settings. Feedback as proven to be the most facilitative way of responding to the behavior of others. Unfortunately many of us carry certain non-helpful emotional learnings and habits with regard to listening skills. What are some of the usual non-helpful methods of responding to others?

Some of us like to provide solutions--

- WE order, direct, or command, telling the other person to do something.
- WE warn, threaten, or promise, telling the other what consequences will occur if he/she does something.
- WE moralize or preach, invoking an outside authority as an accepted truth or law.
- WE advise, giving solutions or suggestions, providing answers.
- WE lecture, giving logical arguments, facts, counter arguments, or information of our own opinions.

Others of us like to give cut-down messages--

- WE judge, criticize, or disagree, blaming or making a negative judgment or evaluation of another.
- WE name call, label or stereotype, putting others into categories, shaming them.

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[1]See Practical Pointers The Assessment Process in Recreation with Severely and Profoundly Retarded Populations (Volume II, Number 1, 245-26364) and Recreation Programming Hierarchy with Severely and Profoundly Retarded Populations (Volume II, Number 3, 245-26424), available at $2.00 each from AAHPERD Publications (P. O. Box 704, 44 Industrial Park Circle, Waldorf, Maryland, 20601) for specific assessment information and protocols adaptable for populations addressed in this publication.

- WE interpret or analyze, telling the other what his/her motives are or analyzing why he/she is doing or saying something.

- WE probe, question, interrogate, trying to find reasons, motives, searching for more information for our benefit.

To become a more effective listener a therapeutic recreation specialist must learn to avoid these common pitfalls. A noncommittal acknowledgement is necessary, one that opens the door to further communication by providing an invitation to say more. To communicate acceptance of the sender's feelings and leave responsibility for problem solving with the sender, yet remain involved, requires considerable personal expertise. Each member of the psychiatric treatment team is obligated to pursue these skills continually. A substantial professional investment is required. How do you become an effective helping agent for another?

Therapeutic Use of Self in One-to-One Relationships

As part of the mental health treatment team a therapeutic recreation specialist has responsibility to identify those things which dehumanize patients as well as those things which have positive effects. This requires a positive communication pattern. Elements of this pattern involve relating through meaningful dialogue, openness and closeness, understanding, consistency, and empathy.

Meaningful dialogue is pertinent, relevant, and appropriate, not small talk, directions, or orders. It involves timing, knowing when to speak, what to say, how to say it, and when to be silent.

Openness and closeness implies caring. It is characterized by capacity to allow opposing problems or feelings to coexist without succumbing to the need to avoid discomfort or premature closure of the interaction. The purpose is to free the patient through emotional experience and develop confidence and trust in other human beings.

Understanding, as a skill, is to acknowledge uniqueness of another. This gives the patient endurance and courage to face problems. Emotional functioning and personality structure of the patient are products of higher life-long personality development and current interpersonal stresses. To develop understanding we must ask ourselves continually, what things have gone on in past experiences of this patient which might affect current upset behaviors.

Consistency helps lessen a patient's anxiety by simplifying decision-making and avoiding uncertainties. A positve attitude and approach go hand in hand with consistency.

Empathy is a slow process involving warmth and support. All mentally ill patients experience some loss of self-esteem and self-confidence. If the therapeutic relationship is to be helpful it must help restore and re-establish these characteristics.

Each practitioner brings into a therapeutic relationship unique contributions, that is, what he/she is as a person which is different from any other person. Degree of self-understanding directly relates to effectiveness of each practitioner in one-to-one relationships. Therapeutic involvement is moving toward knowing a patient as

a unique human being. It is an ongoing process, representing another means by which the practitioner demonstrates consistency, understanding, and acceptance of the patient. It begins with the very first interactional encounter. For the therapeutic recreation specialist this usually means the initial assessment interview.

Elements of an Assessment

Interviewing

Interviewing is a goal-directed method of communication, a process used in the therapist-patient relationship that may extend for some time. In the first phase of the relationship the therapist focuses on getting to know the patient and on having the patient become acquainted with the therapist to establish a trusting relationship.

In the second or working phase of the relationship purposes of the interview vary from time to time. Goals originally formulated may be modified. It is more common to find a therapist beginning to structure an interview so that the patient can talk about his/her feelings, to ventilate. This is helpful because tensions are released.

In the third or terminal phase of the interview process the therapist uses the interview to help the patient understand and resolve his/her own problems and feelings. Interviewing techniques assist a patient in becoming more independent and consequently better able to live effectively without professional help.

Interviewing is communication through speech. While meaning of a sender's message is important in terms of his/her choice of words, the receiver does gather additional data through the sender's tone of voice, facial expressions, and body movements. This law of human interaction applies to both patient and therapist during the interview process. What are some unique elements of the interview process?

Dynamics of Interview Assessment Interaction

The therapist must interrupt only to seek clarification or make statements that indicate understanding. The task is to keep communications open, encourage spontaneity, but also focus on problems the patient brings up and to encourage expression of feelings. Movement of the interview depends on the practitioner being an excellent listener. An alert listener picks up a patient's verbal and nonverbal leads, and recognizes clues or signals from the patient. A therapeutic recreation specialist as a good listener not only hears words that are spoken, but also sees body gestures accompanying words. In addition he/she categorizes a patient's statements into themes. This is a shorthand method of thinking which is necessary because no one can store vast numbers of words in the memory. Instead, ideas are memorized that can later be recalled. This is an important skill to acquire as many themes may reoccur from conference to conference.

A therapist should use various means to keep an interview moving. This does not automatically mean the goal is to keep a patient talking, but means that efforts be made to continue the thought process and the sharing of ideas and feelings. A therapist tries to use as few words as possible so that his/her words do not interrupt

the patient's or that his/her thoughts unduly influence those of the patient. Such statements as "Tell me more about it," "Go on in that area," and "That interests me" are useful in encouraging the patient. They also indicate that although the therapist is listening he/she needs more information to understand more fully. It is useful to say, "I don't understand. Could you tell me again?" or "Could you tell me more?" if a therapist is really unsure of the meaning of a patient's statements. This questioning may be necessary as many areas need to be addressed.

Eclectic Approach Essential

Some essential elements with which a therapeutic recreation specialist must deal include response to stress, coping and defense mechanisms, interpersonal relationships, motivation and life-style, thought processes and verbal behavior, nonverbal behavior, awareness and handling feelings, talents, strengths and assets, and the introspective of the self. Successful assessment and interpretation of patient behavior depend upon perceived interrelationships of these factors.

Response to Stress: Coping and Defense Mechanisms. By exploring the patient's responses to past stresses as well as current stress of illness the therapist can assess a patient's overall adaptive ability. Each of us has two rather predictable mechanisms.

- Coping mechanisms are those direct action tendencies aimed at eliminating or minimizing a stressful event. Coping strategies are task and reality oriented--for instance, grieving over the death of a family members.

- Defense mechanisms, on the other hand, falsify reality and are unconsciously determined. Denial as a response to the death of a family member is avoiding reality. One is protected from the loss by denial of its existence.

The greater one's repertoire of responses to stress, the more realistic responses are likely to be. Interview cues and questions--

- Have you experienced a recent stress and how did you manage?

- How do you handle stress on the job or at home?

Interpersonal Relationships. In a person with low self-esteem, the self-system tends toward social isolation. Such a person puts restrictions and stipulations on contacts with others. This enables some measure of security by avoiding anxiety-provoking relationships. Thus, assessment of a patient's interpersonal relationships, by closeness or distance of them, provides data about meeting interpersonal needs and person's self-esteem. Interview cues and questions--

- Do you have close friends? Can you exchange thoughts and feelings with them? What do you do together?

- How do you feel when you are in social situations?

Motivation and Life-Style. An extremely important aspect of motivation is optimism or hope a person feels in pursuing a goal. Motivation, or striving for a goal, requires some measure of hopefulness. Many psychiatric patients, because of

deprivation and frustration, have lost hope and instead are depressed, apathetic, and withdrawn. They are not motivated to pursue goals, having devalued them or having abandoned hope of goal attainment. Yet improvement will be a result, in part, of the patient's motivation for dealing with his/her illness.

Related to motivation is life-style. Inquiries as to a client's life-style may yield data about his/her continuing pattern of assumptions and attitudes. Detailing a typical day's activities may also give clues as to the patient's motives, one's level of aspiration, richness or poverty of activity, and meaning in his/her daily life. Interview cues and questions--

- How do you think things can be different for you, and what can you do about them?
- Are you willing to work and take risks to make changes?
- What seems to interest and motivate you the most?
- I'd like to hear how you spend your time each day.

Thought Processes and Verbal Behavior. Rational or realistic thoughts and disordered or psychotic thoughts are reflected in language. Rational thoughts take place in conscious awareness and, although stimulated by such sources as the unconscious and daydreams are monitored be reason and logic.

Disordered thoughts are directed more by unconscious factors and less affected by reality or logic. A clue to the presence of a thought disorder is disturbance in the association of ideas. Links between thoughts are unclear, thus creating puzzlement in the listener as to how thoughts relate and where the conversation is headed. Further confirmation of the presence of a thought disorder is provided by delusional thought and incoherence. Assessment of thought processes enables differentiating between psychotic or other disturbances, and therefore, the amount of unconscious influence being exerted on the person. Interview cues and questions--if the patient moves lips, appears preoccupied or gestures inexplicably, ask--

- What's happening now?
- Do you have thoughts that disturb you?
- Do you sometimes feel people are talking about you?

Nonverbal Behavior. Nonverbal behaviors or body cues such as body posture, facial expressions, gestures, movements, general appearance, and responses to the interviewer are more spontaneous and harder to fake than verbal behaviors. They can serve to reinforce or contradict verbal communication.

Research has shown that an interviewee desiring to withhold information usually leaks clues about withheld information through nonverbal behavior, particularly of the legs and feet. Knapp (1972) reported that less than thirty-five percent of the social meaning of the situation is verbal; more than sixty-five percent is carried on nonverbally.

Observation of nonverbal communication can expand on the patient's verbal behavior and provide material to pursue with the individual. Interview cues and questions--

- Does the patient sit rigidly, or does he/she show freedom of movement?
- What is the patient's affect as he/she talks?
- What can you tell about the feeling from gestures--foot-tapping, fist-pounding, picking at self?

Awareness and Handling Feelings. Often the process of identifying feelings is blocked by various resistances used by the individual. Resistance prevents the patient's awareness of unpleasant emotions. It is important for the therapist to ask the patient about how he/she is feeling. This helps the individual become more aware of how feelings influence actions. Since most people tend to avoid unpleasant feelings, the therapist needs to be particularly aware of this resistance as the patient is interviewed.

A therapist collects data about the patient's expression or handling of feelings. Is expression blocked? Is expression of feeling incongruent with awareness of that feeling? For example, does the patient handle anger by placating? Interview cues and questions--

- How are you feeling now?
- What do you do when you get angry or sad?
- Tell me about a very happy and a very sad time in your life.

Talents, Strengths, and Assets. Assessment of talents, strengths, and assets, part of the patient's total support system, focuses on healthier attributes of personality and adjustment. Gathering information about assets as well as problems enables a fuller, more balanced view of the person.

By collecting data about the client's strengths, the therapist has a take-off point for deciding, with the patient, on some reachable therapeutic goals. Interview cues and questions--

- What are your assets or strengths?
- What do you like about yourself?
- What do you do well?

Introspective View of the Therapist. When we look at the process of the interview between therapist and patient we are talking about something with an active, alive quality. Aspects of the relationship may involve transference and countertransference. Transference involves repeating early patterns of interpersonal relatedness with present day partners.

Since all people carry around some unfinished business in the area of early childhood experiences, the therapist is also subject to react in a personal, distorted way with the client. This, then, becomes countertransference.

What this means for the therapeutic recreation specialist is ongoing awareness of his/her own unfinished business, how his/her feelings and patterns of behavior might surface in relationships with others.

A therapist's own feelings can lend a very subjective quality to what has been considered a collection of objective data on psychological assessment. Each of us perceives the world a little differently. What we observe cannot be purely objective for it is colored by differences in vision, experiences, labeling of objects, judgment of distances and size, and so forth. Awareness of the instrusion of subjectiveness is the first step in reducing this distortion. The process occuring between patient and therapist, with its subjective quality, provides data worth exploring as part of assessment. By noticing and analyzing our learned responses when confronted with experiences that remind us of earlier ones, we can be a source of data about the patient if we know how this process afffects others. Interview cues and questions--

- How do I feel like responding to the patient--with sympathy, anger, or distrust?
- How does the patient seem to be responding to me? Do I have any clues as to how trusting he/she is of me?
- What personal experiences am I reminded of as the patient talks to me?

A therapist is forever evaluating data from various content areas, seeking relationships and contrasts, disparities and consistencies, and sharing these with the patient. By so doing, he/she assists the patients's progress toward integration and wholeness. Through the interview/assessment various needs, difficulties, and strengths are surveyed. Fruition of this review comes with formulation of a treatment plan and further interventions. These items are geared to help the patient integrate feelings, experiences, and goals.

Treatment Planning As A Process

Treatment planning is a process which starts at the time a patient is admitted and continues through discharge and follow-up, with ongoing review, assessment, and modification of the plan and the goals that it establishes. The Joint Commission for Accreditation of Hospitals (JCAH) has established ten elements in development and review of treatment planning. These include--

1. Reasons for admission.
2. Identification of patient's problems and strengths from the patient and/or significant others.
3. Identification of additional information needed.
4. Documentation of necessary information and initial assessment.
5. Statement of goals in measurable terms.
6. Summary statement demonstrating that available information has been evaluated and that goals are relevant to that individual evaluation.
7. Documentation of who, what, how, when, and where of implementation of the treatment plan.
8. Review of patient's progress towards goals at stated intervals.

9. Revision of plans and goals as indicated and appropriate.

10. Discharge plans and follow-up.

Of these elements of the Individualized Comprehensive Treatment Plan, five, which have not always been included in the past, now require documentation by JCAH. These five are--

1. Including patient, family, and significant others in developing the patient's treatment plans and goals.

2. Writing goals in measurable terms.

3. Stating the patient's strengths, as well as problems, and using strengths in developing treatment plans and goals.

4. Reviewing and revising goals.

5. Planning discharge and follow-up.

Of special significance to the therapeutic recreation specialist is the requirement that goals written in measurable terms now must describe an action or behavior which can be observed and, therefore, measured.

Goals in Measurable Terms

Goals are a required part of the Individualized Comprehensive Treatment Plan. They are the means to assess patient progress or lack of progress by determining to what degrees they are being achieved. They should be--

- Appropriate--related to eliminating or lessening specific problems of the patient.
- Achievable.
- Time projected--the patient and staff should have some idea of how long a period of time will be needed to achieve the goal, and the time expectation should be incorporated in the goal plan. It is important that the goal be reviewed by patient and staff at the end of the agreed-upon time period.
- Important to the patient, family, and significant others, as well as to staff.

In addition, measurable goals should be related to reasons for admission and to problems the patient should work on to be discharged. In other words, goals have to do with why the patient came in and what is necessary to reduce or resolve his/her problems.

Action stated goals should--

- Describe how a patient will be acting or behaving.
- Be measurable.

- Be easily understood by anyone.

- Be appropriate.

Goals should be in measurable terms since they...

...assure that each patient has an Individualized Treatment Plan;
...are predicated upon specificty which requires specific action leaving little room for guessing;
...communicate the same goal expectation to all staff who work with the patient and ensure a commonality of goals; and
...enable those involved in the ongoing treatment of patients, or other qualified persons (e.g., surveyors) to determine what active, meaningful treatment is being carried out.

Goals are often stated in vague or general terms. It is not uncommon, for example, to find goals such as "to improve the patient's appearance" or "to improve the patient's social relationships." While these vague statements indicate areas which need improvement, they do not necessarily mean the same thing for each patient. Neither do they carry the same expectations for all staff. To one staff person improving the patient's social relationships may mean keeping the patient from arguing. To another staff person it may mean helping the patient initiate or sustain conversations, and/or participate in games or group activities. While the patient may need improvement in all of these areas, it might be more achievable to concentrate on one goal at a time, a goal which patient and staff can agree upon. Vague terms cause confusion and cannot be measured. They do not describe what specific action or behavior to be taken is or what specific change will be observed if and when the goal is achieved.

It is also useful to develop reasonable goals. Often goals are so complex that they need to be broken into smaller steps to help ensure success. Failure to achieve goals may result if goals are too difficult or take too long to achieve, thus producing frustration for both the patient and staff.

The Individualized Comprehensive Treatment Plan can be an effective therapeutic tool which is productive, satisfying, and helpful to staff as well as to patients. The success of the Individualized Comprehensive Treatment Plan depends upon--

- Involvement of patient in planning treatment to be provided by staff.

- Conviction, willingness, and persistence of staff in spending required time to develop listening and communication skills necessary to formulate the plan.

- Ongoing evaluation of the effectiveness of the plan.

- Willingness of each team member to accept his/her responsibilities in carrying out specific goals assigned.

When patients are involved in the choice of goals--self-determination--including utilization of the patient's strengths--building self-esteem and self-worth--both staff and patient will know when a goal has been achieved. This process is much more likely to produce more trusting and therapeutic relationships between staff and patient.

During the active treatment process the therapeutic recreation specialist must closely observe effects of prescribed programing. Careful clinical observation must be carefully documented for benefit of other members of the treatment team.

Descriptive Observation and Charting

All clinicians must chart only what is observed, that is, what is seen and heard; do not give opinions; do not interpret. Use simple descriptive terms. Do not use diagnostic psychiatric or indefinite terms such as hallucinations, bizarre, delusional, confused, provocative, uncooperative, upset, socializing, inappropriate.

Whether a patient is experiencing delusions or hallucinations, and if the latter, what type, can be very important as diagnostic clues and indications of degree of illness. However, what the patient is actually experiencing can be easily misunderstood. For this reason, those observing and reporting such incidents must do so in an objective and descriptive manner. It may be well to ask the patient questions about his/her behavior at such times for further clarification.

Do describe what you saw or heard that indicated these situations existed. Some examples of descriptive charting might help clarify this--

Not "...seems to be upset," but, how he/she acted upset.

For example--"Moving restlessly in chair."
"Pacing the hall smoking many cigarettes."
"Talking in high shrill tone about _____."

Not "...socializing with other patients," but, what they were doing.

For example--"Visiting spontaneously with those near."
"Seeks others out to play cards with him/her."
"Responds readily when others invite to play."
"Wandering about with other teenagers stops to talk in undertones or laughs uproariously frequently."
"Gathered in dayroom talking intently with other teenagers."

Not "...pleasant ward manner," but, how expressed.

For example--"Visiting spontaneously in pleasant tone."
"Greets others with smile and pleasant voice."

Not "...disapproves of all aides," but, how shown in response to what.

For example--"Whenever aide approached glared at him/her, then walked away."
"When asked to join group, turned back, did not respond to aide, muttered in undertone to Mr. C. (patient)."

Not "...uncooperative," but, what you wanted him/her to do and how he/she responded.

For example--When asked to go to recreation area answered, "What for!" Tone surly.

Not "...enjoyed very much," but, how he/she expressed enjoyment.

For example--"Eyes shining. Laughing freely."
"Described game with pleasure."

Do not waste time to chart "usual ward manner." It tells nothing about the patient. Remember to record evidence of adequate or improved functioning to indicate how well the patient is, as well as how ill.

Summary

Assessment and evaluation are bases for developing individualized recreation treatment plans. Being systematic, consistent, and thorough are crucial to success. The therapeutic recreation specialist is forever evaluating data from various content areas, seeking relationships and contrasts, disparities and consistencies, and sharing these with the patient. By doing so the patient is assisted in progressing toward integration and wholeness.

A therapeutic recreation specialist, as a psychiatric clinician, makes assessments and plans interventions using a broad theory base. Within this the therapeutic recreation specialist is aware of him/herself as a person as well as a clinician, and considers how the self is being utilized in working with clients. This is an introspective process of interactions and thoughts occurring between self and client. Through development of effective communication skills, as well as skills involved with observation and descriptive charting, therapeutic goals formulated during the assessment process are furthered. A therapeutic recreation specialist shares his/her assessment of various needs, difficulties, and strengths, in planning for further interactions with the patient to help integrate experiences, feelings, and goals.

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